PERM is a partnership between Federal and state agencies that enhances collaboration and measures improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP).

Payment Error Rate Measurement (PERM) Process

Frequently Asked Questions about the PERM Program

I. BACKGROUND

What is PERM?

The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP) and produces state and national-level error rates for each program. The error rates are based on reviews of Medicaid and SCHIP fee-for-service (FFS) and managed care payments made in the Federal fiscal year (FY) under review. States conduct eligibility reviews and report eligibility-related payment error rates also used in the national error rate calculation.

Why was the PERM program created?

PERM was developed by the Centers for Medicare & Medicaid Services (CMS) to comply with the Improper Payments Information Act (IPIA) of 2002. The IPIA requires the heads of Federal agencies, including the Department of Health and Human Services (HHS), to annually review programs it administers and identify programs that may be susceptible to significant improper payments, estimate the amount of improper payments, submit those estimates to Congress, and submit a report on actions the agency is taking to reduce the improper payments. The IPIA directed the Office of Management and Budget (OMB) to provide guidance on implementation. OMB identified Medicaid and SCHIP as programs at risk for significant improper payments. Therefore, HHS must report the estimated error rates for the Medicaid and SCHIP programs each year for inclusion in the Performance and Accountability Report (PAR). CMS implemented the PERM program in a final rule published on August 31, 2007 (72 FR 50490).

What are the benefits of the PERM program?

The PERM program:

- Identifies program vulnerabilities that result in improper payments.
- Promotes efficient Medicaid and SCHIP program operations.
- Helps to ensure medical services are provided to the truly eligible.

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How often are states measured under PERM?

PERM uses a 17-state rotational approach to measure improper payments in Medicaid and SCHIP for the 50 states and the District of Columbia over a three-year period. As a result, each state is measured once, and only once, every three years. The rotation allows states to plan for the reviews because they know in advance when they will be measured. The following table illustrates the state rotation by fiscal year:

States Selected for Medicaid and SCHIP Improper Payments Measurement

FY 2007	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
FY 2008	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington
FY 2009	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming

Who are the key partners, and what are their responsibilities?

PERM partners include the Office of Management and Budget (OMB), the Department of Health and Human Services (HHS), CMS and its contractors, state Medicaid and SCHIP agencies, and the PERM Technical Advisory Group (TAG). A brief description of the role of each of these partners is provided below.

- The Federal agencies that oversee the operation of the PERM program are OMB, HHS, and CMS. These agencies structure the parameters for the improper payments measurement under PERM through legal and policy decision-making processes. Within CMS, the Office of Financial Management (OFM) and the Center for Medicaid and State Operations (CMSO) work closely to ensure the measurement minimizes cost and burden and is implemented consistently across the states.
- The contractors' primary responsibilities include the following:
  - Statistical Contractor (SC)
    - Review each state's eligibility sampling plan and work with the state if necessary to achieve an approvable plan.
    - Sample FFS line items and managed care capitation payments on a quarterly basis, which is done through the following steps:
      — Determine the sample size of line items/capitation payments that will be reviewed for each state annually and per quarter,
      — Select a random sample of line items/payments per quarter for review from each of the 17 states being measured for that year.

- Collect eligibility error rates from the states and FFS and managed care error findings from the Review Contractor (RC).
- Calculate each state's Medicaid and SCHIP program error rates using findings from the medical reviews, data processing reviews, and eligibility reviews and calculate a national error rate for Medicaid and SCHIP based on the states' error rates.

- Documentation/Database Contractor (DDC)
  - Obtain and store state policies that govern the Medicaid and SCHIP programs by which the reviews are conducted.
  - Receive the sampled claims from the SC and communicate with each state to populate the details for these claims.
  - Map all sampled claims data to a standard format for use by the RC.
  - Request medical records from the identified providers to support payment of the claims undergoing a medical review.

- Review Contractor (RC)
  - Conduct medical record reviews for sampled FFS claims and data processing reviews on sampled FFS and managed care claims.
  - Re-review claims if the state disagrees with the error findings through the difference resolution process.

- The state Medicaid & SCHIP agencies' primary responsibilities include the following:
  - Provide a representative to spearhead the PERM program and coordinate activities across sister agencies;
  - Provide Medicaid and SCHIP claims data to CMS contractors;
  - Assist CMS contractors with on-site data processing reviews;
  - Assist medical providers to submit documentation required for medical reviews;
  - Conduct improper payment reviews based on erroneous eligibility determinations;
  - Provide subject matter expertise and information on Medicaid and SCHIP payment processes and program policies;
  - Participate in CMS-sponsored cycle calls;
  - Contribute to the identification and prioritization of potential vulnerabilities through data analysis;
  - Develop and implement corrective actions to reduce improper payments; and
  - Provide feedback and updates to CMS, its contractors, state managers, and other interested parties.

- Some state PERM representatives are also nominated to the PERM TAG to analyze key program issues and recommend solutions to improve program operations and to gain efficiencies.

II. PERM PROCESS

Are Medicaid and SCHIP treated separately?

Yes. Medicaid includes all claims that are paid (or would have been paid if not denied) with Title XIX funds. SCHIP includes all claims paid (or would have been paid if not denied) with Title XXI funds, including Medicaid-expansion cases that are funded under SCHIP.

What claims are sampled under PERM?

Every individually-priced service paid at the beneficiary level and adjudicated by Medicaid or SCHIP for payment should have the opportunity to be randomly sampled. Each claim meeting these criteria is captured in one of the following four program areas: Medicaid FFS, Medicaid managed care, SCHIP FFS, SCHIP managed care.

What is the timeframe for the PERM cycle?

The following is an example timeline of a typical PERM cycle:

TIMEFRAME	EVENT
August 1	States submit eligibility sampling plans to the SC for approval
October 1	States begin the eligibility review process
December 1	States submit Medicaid and SCHIP medical policies in effect for the review period to the DDC
January 15	States submit 1st quarter (October–December) adjudicated claims to the SC
February 1	State submits 1st quarter policy updates to the DDC
April 15	States submit 2nd quarter (January–March) adjudicated claims to the SC
May 1	States submit 2nd quarter policy updates to the DDC
July 15	States submit 3rd quarter (April–June) adjudicated claims to the SC
August 1	States submit 3rd quarter policy updates to the DDC
October 15	States submit 4th quarter (July–September) adjudicated claims to the SC
November 1	States submit 4th quarter policy updates to the DDC
July 1	States submit eligibility error rate and findings to the SC
Throughout PERM process	States identify and resolve differences in review findings with the RC

How are improper payments measured for the FFS and managed care components of PERM?

The following describes the detailed role of the contractors in the FFS and managed care components of PERM. Please refer to the PERM website at http://www.cms.hhs.gov/PERM for more information.

Statistical Contractor (SC)—Sample Selection

Each quarter throughout the fiscal year, the SC collects the universe of claims data for Medicaid and SCHIP FFS and managed care from the states. The universe includes claims that are paid with Federal Financial Participation (FFP) for Medicaid and SCHIP services, including payments made outside of the state's Medicaid Management Information System (MMIS) and payments made at the local level. Many states have benefit programs that are financed by state-only funds with no Federal money involved. Only claims with FFP should be included in the universe.

The SC draws a random sample of claims from the quarterly universes submitted by the states. The annual sample size for FFS is approximately 1,000 claims per program and 500 claims per program for managed care. Since claims data is submitted quarterly by the states, each quarter is treated as a separate universe and sampled accordingly. Thus, the annual target sample size is subdivided into fourths, so that FFS claims will have a sample size of approximately 250 for each of the four quarters of data. Managed care samples will be approximately 125 for each of the four quarters.

PERM uses a stratified random sampling design. The universe is stratified by payment amount into five or more strata, and an equal number of claims are selected from each strata. This approach guarantees that strata with a large number of claims will not be overrepresented and strata with a small number of claims will be adequately represented.

After drawing the samples, the SC sends the samples to the DDC.

Documentation/Database Contractor—Populating Claims

While the SC samples claims, the DDC begins requesting state Medicaid and SCHIP policies that are used for the medical and data processing reviews.

The SC provides a list of sampled claims to the DDC and the RC. The sample list contains minimum data information because it is less burdensome on states to provide minimum universe data and enhance the information on the sampled claims (called "populating the sample"). The DDC sends the states a list of their sampled claims, and the states populate the claims.

After the samples are populated and returned to the DDC, the DDC standardizes the format of the claims data and sends it to the RC for data processing reviews. Then, the DDC contacts those providers whose FFS claims were sampled to obtain copies of medical records for the claims in question. Providers have 60 calendar days to comply and send copies of medical records for the selected claims. If the provider does not respond, the state is notified of an error due to no documentation. Otherwise, when the DDC receives medical records from the providers, the records are sent to the RC for the medical reviews.

Review Contractor—Medical and Data Processing Reviews

The RC schedules on-site data processing reviews with each of the states. For FFS claims, the data processing review includes examining line items in each claim to validate that it was processed correctly. The RC also performs data processing reviews on managed care claims for the accuracy of the processing of the capitation payment or premium.

The RC also begins medical reviews on FFS claims. Managed care claims are not subject to medical reviews because there is no specific service rendered on which to make a medical necessity determination. The RC examines the medical record to ensure there is documentation that

supports medical necessity and to verify coding accuracy. If the record does not contain sufficient documentation, the RC notifies the DDC that additional documentation is needed. The provider has a new timeframe of 15 calendar days to provide the missing documentation. This new timeframe is not part of the original 60 days that the provider initially had to submit the medical records.

Once the reviews are completed, the findings are posted to the RC's secure website, which can be reviewed by the individual states.

Difference Resolution

States can challenge an improper payment finding through the difference resolution process. States are notified when an error is found through the RC's website. Errors due to no documentation can not be disputed in the difference resolution process. However, all other errors including errors due to insufficient documentation can be disputed.

States can file a difference of finding through the RC's website. The RC will then re-review the case along with documentation provided by the state to support its claim of a correct payment, and decide to uphold or reverse the error.

CMS Appeals

If the state still believes that the error finding is inaccurate, it can appeal to CMS if the amount in difference is $100 or greater. CMS obtains the claim and/or medical records, the policies pertaining to the claim, and the RC's notes for review. CMS posts its decision to the RC's website. CMS' decision is final.

How is the eligibility error rate determined?

States are responsible for the eligibility measurement of Medicaid and SCHIP improper payments due to erroneous eligibility determinations for program benefits. States also review negative case actions to assess if beneficiaries are being denied benefits or terminated from the programs incorrectly.

The PERM eligibility measurement is divided into four stages:

- Random sampling of Medicaid and SCHIP beneficiary cases from monthly universes
- Review of these cases to verify eligibility
- Payment review to identify payments associated with the cases
- Error rates calculated as a result of the reviews

Sampling

Unlike the FFS and managed care components of PERM, eligibility is sampled monthly instead of quarterly and is a case-based sample rather than a claims-based sample. A unique universe is created monthly of all active and negative cases from which cases are randomly sampled.

- "Active cases" are individuals currently enrolled in Medicaid or SCHIP. The active cases are separated into three strata: applications, redeterminations, and all other cases.
- "Negative cases" are individuals denied or terminated from Medicaid or SCHIP.

For a state's initial year participating in PERM, the total annual sample size is 504 active cases and 204 negative cases each for Medicaid and SCHIP. This sample size is determined to have a high probability of achieving an error rate within 3 percentage points with a 95 percent level of

confidence. In the state's subsequent PERM year, the sample size for each program is determined by its error rate in its last PERM year. Below is a chart showing the precision levels for different sample sizes.

Probability of Achieving Precision for Certain Error Rates and Sample Sizes

Sample Size	Error Rate 0.03	0.04	0.05	0.06	0.07	0.08
250	49.2%	6.0%	0.4%	0.0%	0.0%	0.0%
300	86.5%	26.3%	2.7%	0.2%	0.0%	0.0%
350	98.8%	62.7%	13.5%	1.3%	0.1%	0.0%
400	100.0%	90.4%	39.9%	6.9%	0.7%	0.0%
450	100.0%	98.9%	73.0%	23.8%	3.6%	0.3%
500	100.0%	100.0%	93.2%	52.8%	13.7%	1.9%
600	100.0%	100.0%	99.9%	95.3%	64.2%	22.9%
650	100.0%	100.0%	100.0%	99.4%	86.6%	47.7%
700	100.0%	100.0%	100.0%	100.0%	96.9%	73.7%

Eligibility Reviews

After selecting the monthly sample, each case in the sample is reviewed to verify eligibility. The purpose of the eligibility review is to verify beneficiary eligibility, not that the caseworker acted correctly. Eligibility reviewers look to the beneficiary's categorical and financial eligibility to determine if the person is eligible or ineligible. For active case reviews, a case is correct if the beneficiary is determined "eligible" and is in error if the beneficiary is determined "ineligible" for Medicaid or SCHIP. Active cases are considered "undetermined" if eligibility cannot be verified with documentation provided or obtained. Negative cases are reviewed to determine if applicants and beneficiaries are denied or terminated in error. Cases denied or terminated in error should be referred back to the agency responsible for the eligibility determination for a redetermination for benefits.

Payment Reviews

After eligibility reviews of all of the sampled cases are complete, states begin to collect payments made for each case. The PERM eligibility timeline provides for a 5-month timeframe in which states collect payments for services rendered in the month reviewed for eligibility and paid over the next 4 months. States determine dollars spent correctly on behalf of the beneficiary and dollars spent in error. This is the basis for calculating the payment error rate.

Eligibility Error Rates

States calculate the following three eligibility error rates:

Reviews for eligibility-active case error rates—

- An active case error rate is based on the number of cases determined eligible in error.

- A payment error rate is dollar weighted and includes dollars spent for services in which an active case is found to be ineligible for the program or for the services rendered.

Reviews for improper denial/termination-negative case error rate—

- A negative case error rate is based on the number of cases denied or terminated in error.

States also can designate cases as "undetermined" when eligibility cannot be definitively determined. Undetermined cases are documented and payments are collected and reported separately from the error rates. States calculate and submit their respective error rates to the SC, who then calculates the national eligibility error rates. The eligibility error rates are included with the FFS and managed care error rates in the overall national Medicaid and SCHIP program error rates.

Where can I get more information about the PERM program?

Please visit the PERM website at http://www.cms.hhs.gov/PERM for more information about the program.

Glossary of Commonly Used Terms

Adjudicated claim: A claim that has been accepted and reviewed by the state's claims processing system and the decision to accept or deny the claim has been made.

Capitation: A fixed payment, usually made on a monthly basis, for each beneficiary enrolled in a managed care plan or for each beneficiary eligible for a specific service or set of services.

Claim: A request for payment, on either an approved form or electronic media, for services rendered relating to the care and treatment of a disease or injury or for preventive care. A claim may consist of one or several line items or services.

Denied claim or line item: A claim or line item that has been accepted by the claims processing system and adjudicated for payment but not approved for payment in whole or in part.

Difference Resolution: A process that allows states to dispute the Review Contractor's error findings.

Eligibility error: An eligibility error occurs when a person is not eligible for the program or for a specific service and a payment for the sampled service or a capitation payment covering the date of service has been made.

Fee-for-Service (FFS): A traditional method of paying for medical services under which providers are paid for each service rendered.

Managed care: A system where the state contracts with health plans on a prospective full-risk or partial-risk basis to deliver health services through a specified network of doctors and hospitals. The health plan receives a capitated payment from the state and is then responsible for reimbursing providers for specific services delivered.

Medicaid: A joint Federal and state funded program that provides medical care to a category of people with limited income and resources.

Medicare: The Federal health insurance program for people 65 years of age or older and certain younger people with disabilities or End Stage Renal Disease.

Overpayment: Overpayments occur when the state pays more than the amount the provider was entitled to receive or paid more than its share of the cost.

Paid claim: A claim or line item that was accepted by the claims processing or payment system, adjudicated for payment, determined to be a covered service eligible for payment, and for which a payment was issued or no payment was due (i.e. because a third-party insurer paid).

PERM: The Payment Error Rate Measurement program that measures improper payments in Medicaid and State Children's Health Insurance Program (SCHIP).

Sample: A random sample of claims or cases selected from the universe (see "universe" definition below).

SCHIP: The State Children's Health Insurance Program which is a state-administered program funded jointly by states and the Federal government that provides health coverage to uninsured, low-income children not otherwise eligible for Medicaid.

Underpayment: Underpayments occur when the state pays less than the amount the provider was entitled to receive or less than its share of the cost.

Universe: The universe is the set of sampling units from which the sample is drawn and the set of payments for which the error rate is inferred from the sample.

Commonly Used Acronyms

CMS: the Centers for Medicare & Medicaid Services

DDC: Documentation/Database Contractor

FFS: Fee-for-Service

HHS: the Department of Health and Human Services

IPIA: Improper Payments Information Act of 2002

MMIS: Medicaid Management Information System

OMB: the Office of Management and Budget

PAR: Performance and Accountability Report

PERM: Payment Error Rate Measurement

RC: Review Contractor

SC: Statistical Contractor

TAG: Technical Advisory Group

Websites

CMS Websites
Homepage: http://www.cms.hhs.gov
PERM Website: http://www.cms.hhs.gov/PERM
PERM Regulations: http://www.cms.hhs.gov/PERM02_lawsandregulations.asp

State Medicaid Agencies
National Association of State Medicaid Directors: http://www.nasmd.org/links/state_medicaid_links.asp

Public Human Service Programs
American Public Human Services Association: http://www.aphsa.org